



# TRINITY CHIROPRACTIC

9204 Taylorsville Rd. Suite 110, Louisville, KY 40299 Phone: (502) 267-3040 Fax: (502) 267-0415

File: TJ

## PATIENT INFORMATION

Full Legal Name: \_\_\_\_\_  
Address: \_\_\_\_\_  
City: \_\_\_\_\_ State: \_\_\_\_\_ Zip: \_\_\_\_\_  
Home Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  
Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_  
Email: \_\_\_\_\_

Do you want reminders?  Text  Email  Call

Cell Phone Carrier (for text reminders): \_\_\_\_\_

Children's Names \_\_\_\_\_ Ages \_\_\_\_\_

### HOW DID YOU HEAR ABOUT US?

Date of Birth: \_\_\_\_/\_\_\_\_/\_\_\_\_ Sex: M F Age: \_\_\_\_\_

Social Security #: \_\_\_\_\_

Occupation: \_\_\_\_\_  
 Full-time  Part-time  Unemployed  Retired

Employer: \_\_\_\_\_

Single  Married  Widowed  Separated  Divorced

Spouse's Name: \_\_\_\_\_

Spouse's Occupation: \_\_\_\_\_

Spouse's Employer: \_\_\_\_\_

### EMERGENCY CONTACT

Name: \_\_\_\_\_

Relationship: \_\_\_\_\_

Home/Cell Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_

Work Phone: (\_\_\_\_) - \_\_\_\_ - \_\_\_\_\_ Ext: \_\_\_\_\_

## PAYMENT INFORMATION

Who is responsible for this account?: \_\_\_\_\_

Relationship to patient: \_\_\_\_\_

Insurance Company: \_\_\_\_\_

Policy #: \_\_\_\_\_

Group#: \_\_\_\_\_

Date of Birth of Policy Holder: \_\_\_\_/\_\_\_\_/\_\_\_\_

*(This information is necessary to verify your insurance benefits)*

*For PERSONAL INJURY or WORKERS' COMPENSATION*

Insurance Company: \_\_\_\_\_

Claim #: \_\_\_\_\_

Have you retained an attorney? Y N

Attorney Name: \_\_\_\_\_

Attorney Phone #: \_\_\_\_\_

Attorney Address: \_\_\_\_\_

## OTHER DOCTORS & PHYSICIANS

Previous Chiropractor: \_\_\_\_\_

Date of Last Visit: \_\_\_\_\_

Reason for Leaving: \_\_\_\_\_

Primary Care Provider: \_\_\_\_\_

Office Name: \_\_\_\_\_

Phone #: \_\_\_\_\_

(ADULT)

Dr. Initials: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

**PATIENT CONDITION**

*Please describe only one area at a time from most severe to least severe (ex: neck, mid-back, low back)*

Chief Complaint: \_\_\_\_\_

Where is the pain? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

What caused this condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain (10 = severe): 1 2 3 4 5 6 7 8 9 10

Describe the pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

Burning  Tingling  Cramps  Stiffness  Swelling  Other: \_\_\_\_\_

How often is this pain?  Constantly  Frequently  Occasionally  Intermittently  
(% of day): (100%) (75%) (50%) (25%)

How long do the symptoms last? \_\_\_\_\_ seconds minutes hours days weeks

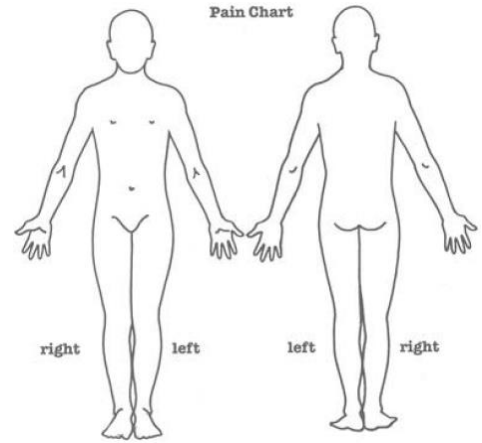
Does this condition radiate/refer to other areas? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Is this problem due to:  Auto Accident  Work Injury

What have you done to relieve the symptoms? \_\_\_\_\_



(Mark the picture above where you are feeling pain)

- Aching Pain
- Sharp Pain
- Burning Pain
- Numbness/Tingling

**PATIENT CONDITION**

*Please describe only one area at a time (ex: neck, mid-back, low back)*

Secondary Complaint: \_\_\_\_\_

Where is the pain? \_\_\_\_\_

When did your symptoms appear? \_\_\_\_\_

What caused this condition? \_\_\_\_\_

Is this condition getting progressively worse?  Yes  No  Unknown

Rate the severity of your pain (10 = severe): 1 2 3 4 5 6 7 8 9 10

Describe the pain:  Sharp  Dull  Throbbing  Numbness  Aching  Shooting

Burning  Tingling  Cramps  Stiffness  Swelling  Other: \_\_\_\_\_

How often is this pain?  Constantly  Frequently  Occasionally  Intermittently  
(% of day): (100%) (75%) (50%) (25%)

How long do the symptoms last? \_\_\_\_\_ seconds minutes hours days weeks

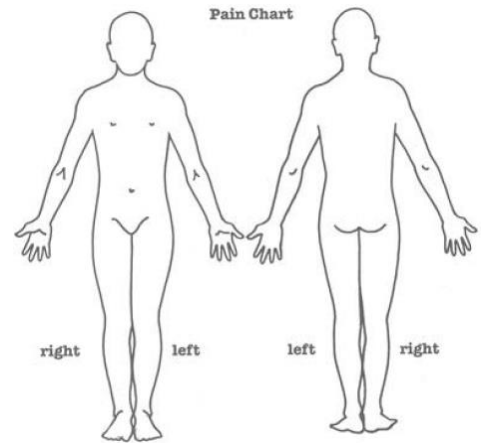
Does this condition radiate/refer to other areas? \_\_\_\_\_

What makes it worse? \_\_\_\_\_

What makes it better? \_\_\_\_\_

Is this problem due to:  Auto Accident  Work Injury

What have you done to relieve the symptoms? \_\_\_\_\_



(Mark the picture above where you are feeling pain)

- Aching Pain
- Sharp Pain
- Burning Pain
- Numbness/Tingling

(ADULT)

Dr. Initials: \_\_\_\_\_

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

**HEALTH HISTORY**

<u>Injuries/Surgeries you have had:</u>	Description	Date
Auto Accident <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Slips/Falls <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Broken Bones <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Surgeries <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Hospitalized <input type="checkbox"/> Yes <input type="checkbox"/> No	_____	____/____/____
Other:	_____	____/____/____

<u>Current Medications:</u>	For what?	<u>Facility of your last:</u>	Date
_____	_____	X-RAY _____	_____
_____	_____	MRI _____	_____
_____	_____	CT _____	_____
_____	_____	BONE SCAN _____	_____

**PAST MEDICAL HISTORY**

Have you ever been diagnosed as having or have suffered from? (Place a check mark by conditions that apply to you)

- |  |   |   |
|--|---|---|
| <input type="checkbox"/> High/Low Blood Pressure   | <input type="checkbox"/> Alcoholism           | <input type="checkbox"/> Congenital Disease _____ |
| <input type="checkbox"/> Circulatory Problems      | <input type="checkbox"/> Osteoarthritis       | <input type="checkbox"/> Gall Bladder             |
| <input type="checkbox"/> Cancer (type)_____        | <input type="checkbox"/> Rheumatoid Arthritis | <input type="checkbox"/> Ulcers                   |
| <input type="checkbox"/> Strokes                   | <input type="checkbox"/> Pace Maker           | <input type="checkbox"/> Excessive Bleeding       |
| <input type="checkbox"/> Broken or Fractured Bones | <input type="checkbox"/> Seizures/Convulsions | <input type="checkbox"/> Coughing Blood           |
| <input type="checkbox"/> Eating Disorder           | <input type="checkbox"/> Drug Addiction       | <input type="checkbox"/> Hernia _____             |
| <input type="checkbox"/> Epilepsy                  | <input type="checkbox"/> AIDS/HIV Positive    | <input type="checkbox"/> Depression               |

Please list any other health problems you have: \_\_\_\_\_

**FAMILY HISTORY**

Please indicate which conditions have been experienced by your family members by marking appropriate boxes (M=Mother & F=Father)

Father: living deceased - cause: \_\_\_\_\_ Mother: living deceased- cause: \_\_\_\_\_

<b>M F</b>	<b>M F</b>	<b>M F</b>
<input type="checkbox"/> <input type="checkbox"/> Cancer _____	<input type="checkbox"/> <input type="checkbox"/> Tuberculosis	<input type="checkbox"/> <input type="checkbox"/> Asthma
<input type="checkbox"/> <input type="checkbox"/> Diabetes	<input type="checkbox"/> <input type="checkbox"/> Mental Illness	<input type="checkbox"/> <input type="checkbox"/> Arthritis
<input type="checkbox"/> <input type="checkbox"/> Stroke	<input type="checkbox"/> <input type="checkbox"/> Kidney Disease	<input type="checkbox"/> <input type="checkbox"/> Epilepsy
<input type="checkbox"/> <input type="checkbox"/> Heart Attack/Disease	<input type="checkbox"/> <input type="checkbox"/> Lung Disease	<input type="checkbox"/> <input type="checkbox"/> Other: _____
<input type="checkbox"/> <input type="checkbox"/> Thyroid Disease	<input type="checkbox"/> <input type="checkbox"/> Liver Disease	<input type="checkbox"/> <input type="checkbox"/> Other: _____

**SOCIAL HISTORY**

<b><u>EXERCISE:</u></b>	<input type="checkbox"/> Smoking	Packs/Day: _____
<input type="checkbox"/> Aerobic <input type="checkbox"/> Weight lifting <input type="checkbox"/> Run/Jog <input type="checkbox"/> Walk <input type="checkbox"/> Yoga	<input type="checkbox"/> Alcohol	Drinks/Week: _____
<input type="checkbox"/> Other: _____	<input type="checkbox"/> Coffee/Caffeine	Drinks Cups/Day: _____
How often?: _____	<input type="checkbox"/> Drugs	Type: _____
<b><u>HOBBIES:</u></b> _____	<input type="checkbox"/> High Stress	Reason: _____

Name: \_\_\_\_\_ DOB: \_\_\_\_\_ Date: \_\_\_\_\_ File #: \_\_\_\_\_

**REVIEW OF SYSTEMS**

Please **check Yes or No** to indicate if you currently have any problems in one or more of the following areas?  
 If yes, please circle the problem listed and explain or describe the problem.

SYSTEM	EXAMPLES	YES/NO	DESCRIPTION
GENERAL/CONSTITUTIONAL	Fever Weight loss/gain Tired feeling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
EYES	Blurred vision Eye pain Eye discharge	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
EARS, NOSE, THROAT, MOUTH	Hearing loss Ear ache Nasal congestion, Chronic cough Dry mouth Allergies/Hay fever	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____ _____ _____
RESPIRATORY	Asthma Emphysema Chronic bronchitis Wheezing Shortness of breath	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____ _____
CARDIOVASCULAR	Diabetes Hypertension Heart problems	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
GASTROINTESTINAL	Diarrhea Constipation Hernia Ulcers	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
GENITOURINARY	Painful urination Frequent urination Impotence Jaundice	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
LYMPHATIC	Anemia Bleeding problems Blood transfusions	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____
MUSCULOSKELETAL	Arthritis Joint pain Muscle pain Cramps Stiffness Swelling	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____ _____
SKIN	Pimples Warts Growths Rashes	<input type="checkbox"/> Yes <input type="checkbox"/> No	_____ _____

(ADULT)

Dr. Initials: \_\_\_\_\_